PRINTED: 10/06/2010 FORM APPROVED OMB NO. 0938-0391

	O I OIN WILDION WIL	S WEDIO, ND OEI (NOE)	1000 11	N ZIOI	F CONSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPL	E CONSTRUCTION	COMPLETED
MIND PLAN OF	CORRECTION	IDENTI IOMIONI MONIBELLI	A BUII	DING	4-4	
			B. WIN	G		С
		185089				09/22/2010
NAME OF PR	OVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
				55	0 HIGH ST.	
ROSEWO	OD HEALTH CARE C	INIEK		В	OWLING GREEN, KY 42101	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	OFRIATE
F 490	Continued From pa	age 46	F	490		
	•	de and adequate supervision			This Plan of Correction is the center's	credible
		tesidents #1, #4, #5, #6 and #7	i		allegation of compliance.	
		naviors of grabbing food/drinks.	:		Description and/or execution of this	nlan of correction
	· Telated to titon both	ations of grassing reservations.	:		Preparation and/or execution of this p does not constitute admission or agree	ement hy the
	On 09/01/10 staff	placed bread (regular			provider of the truth of the facts alleg	ed or conclusions
	: consistency) at the	table accessible to Resident	1		set forth in the statement of deficienci	es. The plan of
		rovide supervision to ensure	į	- 1	correction is prepared and/or execute	d solely because
		ot gain access to the bread	Ì		it is required by the provisions of fede	rai ana siate taw.
		owledge of this resident's		į	To answer the parent of all mob	ilo rocidonte
		to obtain food of a different	l i	ŀ	To ensure the safety of all mob on mechanically altered diets w	ith hehaviore
		observed Resident #1 with		į	all direct care staff, licensed nu	rses and
		and and removed it; however,			SRNAs have been in-serviced	
		to choke. Staff initiated the		İ	and all behaviors, to include wa	
		r; however, this method was		i	reaching for objects, to include	
		ne resident stopped breathing			Licensed nurses were educated	d on P&P for
		Emergency Medical Services			documentation requirements, v	ia staff in-
	had to insert a Lar	yngoscope (instrument inserted			services. Information related to	reporting of
	into the airway to p	provide visual access) into the		:	behaviors, adequate supervision	on and seating
		remove the bread with	1		arrangements in dining were al	
	forceps. The resid	tent was sent out to the			staff in-services. In-services w	
	hospital.		!		by the DNS, WS & UMs beginn	
					9/17/10. Staff will not be allow	
		's failure to ensure adequate			until attending all appropriate in	I-301 VICCS.
		rovided for residents' at risk for	İ		The DNS, UMS and Weekend	Supervisor
		ted a situation that had caused	1		initiated in-servicing to all direc	
		ause serious injury, harm,			include licensed nurses and SI	RNAs on
	impairment or dea	th to a resident. Immediate			09/17/10. In-service content in	
		ntified on 09/21/10 and found to	ļ		plans and care plan meetings	
		and was ongoing. Substandard			Seating Designations. In additi	
		as identified at 483.25 Quality of	:		care staff, including Activities,	were educated
	Care. The facility	was notified on 09/21/10.	:		on the Dining Room Seating A	ssignment
	1		!		Chart and on how the chart wa	ıs designed. All
	The findings Inclu-	de:	1		staff was educated that activity	
			•		groups will be assigned accord	
		itions, interviews and record			individual needs as assessed.	
		termined the facility failed to			DDCO initiated Investigative T	
		ans for five residents (#1, #4,			in-servicing on 09/18/10 with the	1e ED and
		the selected sample of five.	:		DNS. The DDCO completed in	
	I Intonioue with etc	off revealed the residents had			all Administrative Staff (ED, DI	NO. UIVI,

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 100410

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	'	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	iG	c	
		185089	B. WING		09/22/2010	
	OVIDER OR SUPPLIER DD HEALTH CARE CEN	TER		REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 490	tables and other resiright consistency foo residents' care plans the residents' behavi and the need for ade supervision to preven Based on observatio reviews, it was deterprovide adequate su accidents for five res #7), in the selected s failed to supervise ar required supervision eating. Facility staff #4, #5, #6 and #7 his food of a different co failed to develop and prevent the residents food/fluids. Refer to Based on observatio review, it was determinated to develop and prevent the residents food/fluids. Refer to Based on observation review, it was determinated to the supervision ascepted professions that were complete a with sufficient inform assessments related development and iminterventions needed five residents (#1, #4 selected sample of find failed to follow its' esprocedures related to information for each	g food off of dining room dents' trays that was not the d for these residents. The were not revised to address ors of grabbing food/drinks quate monitoring and not choking. Refer to F280 ms, interviews and record mined the facility failed to pervision to prevent idents (#1, #4, #5, #6 and ample of five. The facility and monitor residents who due to choking risks while was aware of Residents' #1, story of attempts to obtain insistency than their diets, but implement interventions to a from obtaining the F323 ms, interviews and record hined the facility failed to ords in accordance with all standards and practices and accurately documented, ation regarding resident to problem behaviors and plementation of care plan of for adequate supervision for 1, #5, #6 and #7), in the ve. Additionally, the facility tablished policy and documentation of the resident. Refer to F514.	F 491	This Plan of Correction is the center's allegation of compliance. Preparation and/or execution of this padoes not constitute admission or agree provider of the truth of the facts allege set forth in the statement of deficience correction is prepared and/or executed it is required by the provisions of federic is required b	lan of correction ment by the d or conclusions s. The plan of l solely because al and state law. Activity sor, Rehab crition despiratory ce content dent Health cumenting in I-Hour col. The DNS cryicing staff to s, and upervision. In- propriate ate in- to work until in-service. sible to ior to service will be intation for all utilize d employ ne in-service report all v altered supervision c meeting. day) for four o determine	
			! !		determine	

NAME OF PROVIDER OR SUPPLIER ROSEWOOD HEALTH CARE CENTER		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
INMAGE OF PROVIDER OR SUPPLIER ROSEWOOD HEALTH CARE CENTER SUMMAY STATELEAST OF REPERENCES. FROM SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPERENCES. SUMMAY STATELEAST OF REPORTMENTS. SUMMAY STATELEAST OF REPORTMENTS. SUMMAY STATELEAST OF REPORTMENTS. SUMMAY STATELEAST OF REPORTMENTS. SUBMAY STATELEAST OF REPORTMENTS. SUMMAY STATELEAST OF REPORTMENTS. SUBMAY STATELEAST OF REPORTMENTS. SUMMAY STATELEAST. SUMMAY STATELEAST OF REPORTMENTS. SUMMAY STATELEAST. SUMMAY STATELEAST OF REPORTMENTS. SUMMAY SUMMAY SALTELEAST. SUMMAY STATELEAST. SUMMAY STATELEAST. SUMMAY SUMAY	7111127 12711 47		·	A. BUI	LDING		، ا	,	
INAPID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES FULL PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES AT TAG SUMMARY STATEMENT OF DEFICIENCIES AT TAG SUMMARY STATEMENT OF DEFICIENCIES AT TAG SUMMARY STATEMENT OF DEFICIENCIES AT TAG SUMMARY STATEMENT OF DEFICIENCIES AT TAG SUMMARY STATEMENT OF DEFICIENCIES AT TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED SY PLUI, PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY ON LISE DEPARTMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY ON LISE DEPARTMENT OF DEFICIENCY TAG SUMMARY STATEMENT AND SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT AND SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCY STATEMENT OF THE SUMMARY STA			185089	B. WIN	G			I	
(X4) D (RATE DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LOS IDENTIFYING INFORMATION) F 490 Continued From page 48 procedure, dated 08/06/07, revealed the centor provided supervision to each resident to prevent avoidable accidents and risks, implement interventions to reduce hazards and risks and to monitor the effectiveness and modify approaches when necessary. The center identified hazards and the risks of the resident having an unavoidable accident through Quality Assurance activities, medical history, physical exam and individual observation. Staff was involved in observing and identifying potential hazards. The Center investigated accidents and developed a plan of action to prevent the accident from reoccurring. A review of the Accidents and Supervision to Prevent Accidents Definitions revealed an avoidable accident was when the facility failed to identify: 1. environmental hazards and individual resident risk of an accident, including supervision, conststent with the residents needs, resident's goals, resident's page. An interview with the Administrator, on 09/21/10 at 10-45 AM, revested she made rounds every morning, talked to residents, reviewed 24 hour reports, monitored staff answering call lights, talked with staff and come in on different shifts to try to ensure staff were providing adequate supervision of ferromance improvement program at the Facility. The ED interpretation of the center's acredible allegation of compliance in the center's credible allegation of correction is the center's credible allegation of correction is the center's credible allegation of correction is the center's credible allegation of correction is the center's credible allegation of compliance. F 490 This Plan of Correction is the center's credible allegation of correction is the center's credible allegation of compliance. Preparation andior execution of this plan of correction in the testing allegation of compliance. Preparation andior execution of the trail administrator of center in the facility and administ			TER		5	50 HIGH ST.			
F 490 Continued From page 48 procedure, dated 08/06/07, revoaled the center provided supervision to each resident to prevent avoidable accidents. This included systems to identify and evaluate hazards and risks, implement interventions to reduce hazards and risks and to monitor the effectiveness and modify approaches when necessary. The center identified hazards and the risks of the resident having an unavoidable accident through Quality Assurance activities, medical history, physical exam and individual observation. Staff was involved in observing and identifying potential hazards and developed a plan of action to prevent the facility failed to identify; 1. environmental hazards and individual resident risk of an accident. Lack of Supervision, consistent with the residents needs, resident's goals, resident's page and risks and 3, implement interventions, including adequate supervision, consistent with the resident's needs, resident's goals, resident's page to revent accidents occurred when the center failed to accurately assess a resident to determine whether supervision to avoid an accident or injury was necessary. Refer to F323 An interview with the Administrator, on 09/21/10 at 10-45 AM, revealed she made rounds every morning, talked to residents, reviewed 24 hour reports, monitored staff answoring call lights, talked with staff and come in on different shifts to try to ensure staff were providing adequate supervisin of the residents. She staded she hade rounds every morning, talked to residents, reviewed 24 hour reports, monitored staff answoring call lights, talked with staff and come in on different shifts to try to ensure staff were providing adequate supervising and the residents. She stade she hade rounds every morning, talked to residents, reviewed 24 hour reports, monitored staff answoring call lights, talked with staff and come in or different shifts to try to ensure staff were providing adequate supervising and the residents. She stade she hade rounds every morning, talked to residents, reviewed	ROSEIIO	JD FIERESTI OAKE GEK			В	BOWLING GREEN, KY 42101			
procedure, dated 08/06/07, revealed the center provided supervision to each resident to prevent avoidable accidents. This included systems to identify and evaluate hazards and risks, implement interventions to reduce hazards and risks and to monitor the effectiveness and modify approaches when necessary. The center identified hazards and the risks of the resident having an unavoidable accident through Quality Assurance activities, medical history, physical exam and individual observation. Staff was involved in observing and identifying potential hazards. The Center investigated accidents and developed a plan of action to prevent the accident from reoccurring. A review of the Accidents and developed a plan of action to prevent the accident from revealed an avoidable accident was when the facility failed to identify: 1. environmental hazards and individual resident risk of an accident, including supervision, consistent with the resident's needs, resident's goals, resident's poals, resident's poals, resident's poals, resident's poals, resident's poals, resident's poals, resident's plan of care, and current standards of practice in order to reduce the risk of an accident. Lack of Supervision with the Administrator, on 09/21/10 at 10:45 AM, revealed she made rounds every morning, talked to residents, reviewed 24 hour reports, monitored staff answering call lights, talked with staff and come in on different shifts to try to ensure staff were providing adequate supervision to avoid an accident or injury was necessary. Refer to F323	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO TAG CROSS-REFERENCED TO THE APPROPRIATE				COMPLETION	
nadicinated in daily stand-up meetings and will utilize weekly (Wednesday) IDT	F 490	procedure, dated 08/provided supervision avoidable accidents. identify and evaluate implement intervention risks and to monitor the approaches when neighboring an unavoidable assurance activities, exam and individual involved in observing hazards. The Center developed a plan of a from reoccurring. A Supervision to Prevervealed an avoidable facility failed to identified including supervision risks and 3. implement adequate supervision resident's needs, resident's needs, resident's needs, resident or accurately a determine whether succident or injury was an interview with the at 10:45 AM, revealed morning, talked to reports, monitored stalked with staff and try to ensure staff we	to each resident to prevent This included systems to hazards and risks, ons to reduce hazards and he effectiveness and modify cessary. The center d the risks of the resident le accident through Quality medical history, physical observation. Staff was and identifying potential investigated accidents and action to prevent the accident review of the Accidents and int Accidents Definitions le accident was when the fify: 1. environmental hazards int risk of an accident, in, 2. evaluate the hazards and int interventions, including in, consistent with the sident's goals, resident's plan estandards of practice in order an accident. Lack of lack of adequate supervision occurred when the center assess a resident to upervision to avoid an as necessary. Refer to F323 Administrator, on 09/21/10 and she made rounds every asidents, reviewed 24 hour taff answering call lights, come in on different shifts to are providing adequate	F	490	This Plan of Correction is the center's allegation of compliance. Preparation and/or execution of this plet does not constitute admission or agreed provider of the truth of the facts allegate set forth in the statement of deficiencies correction is prepared and/or executed it is required by the provisions of feder concerns are identified during the (Tuesday) PIC meetings, the auplace on a monthly basis for two on an as needed basis thereafte will be responsible to report all a findings at the monthly PIC mee monthly findings will be reviewed monthly PIC to validate that any concerns were immediately correspondings will be tracked and tree PIC for additional action steps, in The Interdisciplinary Team, to in limited to, (ED, DNS, UM, RD, SDM, Activities Director, will reviewed events during morning Stand-Up reviewing Event Reports, 24-Ho Hospitalizations, Dietary Committed to ensure that all events a investigated to ensure the health overall well-being is met and mather affected residents, other fact residents with the potential to be identify the need for systemic of validate that the PI process is extended that the PI process is extended to the province of the Picker of the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moverall responsibility for the Per Improvement Program at the Fall moveral responsibility for the Per Improvement Program at the Pall moverall responsibility for the Per Improvement Program at the Pall	an of correction and of conclusions. The plan of a solely because al and state law e weekly dits will take of months and art. The DNS audit ting. All dat the identified ected. Indeed at the findicated. Include but no coial Worker wall reside by ur Reports, unications are in, safety and aintained for illity e affected, to anges and ffective. Il compliance if of the compliance are formance accility. The E	to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) I IDENTIFICATION NUMBER: A. BL		IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
	185089	B. WING _	\$4.00 A. (1.00 A. (1.	09/22	; 2/2010
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO	ORRECTION ON SHOULD BE	(X5) COMPLETION DATE
F 490 Continued From page Quality Assurance a was not aware Resident had behaviors of grafood/drinks and that documented in each the Immediate Jeoph 09/22/10. The Immediate of removal was observations, interviverification was made was removed on 09/22/1 date of reword on 09/22/10, the APC direct care staff, lice Registered Nurse AI be seated in the diniresidents who receive mechanically altered On 09/07/10, the care dining room seating #1. On 09/16/10, the reflect a problem of Aspiration related to Behavior , Past Beh liquids, with interver to: provide LCS pure liquids by small sporintake and po fluids, dining room attendaresidents with same	ge 49 ctivities. She revealed she dents #1, #4, #5, #6 and #7 abbing other residents' the information was not a resident's clinical record. If of correction for removal of ardy was received on rediate Jeopardy was verified 0, prior to exit. The alleged 109/22/10. Based on ews and record reviews, the Immediate Jeopardy //22/10. RNP communicated to all insed nurses, State ides, that Resident #1 would ing room at a table with other wed the same type of	F 49	CROSS-REFERENCED TO THE	center's credible of this plan of correction or agreement by the salleged or conclusion ficiencies. The plan of executed solely because of federal and state law late one medical attified in the IDT mentation of the mpliance. The notation to routine systems each Facility and	DATE

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		ONSTRUCTION	(X3) DATE SUR COMPLETE	
		185089	B, WIN			09/22	2/2010
	OVIDER OR SUPPLIER OD HEALTH CARE CEN	TER		550 HIG	IDDRESS, CITY, STATE, ZIP CODE GH ST. ING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 490	awareness as the resand items, with interval limited to: keep the rewhen out of the bed; abnormal behavior. It when reaching; and attend activities. In addition, the Exect of Nursing Services (Operations (DO), and Clinical Operations, (investigation for Resinvestigation consistemedical record review to: the comprehensing Assessments, Reside (RAPs), Comprehensing Additional Communication Boot Seating Arrangement reviewed. The SRN, Dining Room Seating updated for Resident	th a problem of no safety sident grabs out for people rentions to include but not resident in a supervised area notify the nurse of any re attentive to the resident to rencourage the resident to rencourage the resident to rencourage the resident to rencourage the resident to rencourage the resident to rencourage the resident to rencourage the resident to rencourage the resident to rencourage the resident of the District Director of the District Director of DDCO), conducted further redent #1 on 09/19/10. This red of staff interviews and resident #1 on the resident function of the Dinch people in the Dinch people is resident Progress Notes. The Dinch people is resident Progress Notes and the Dinch people in the Dinch p	F	490			
	Behaviors of grabbin tables, including food include but not limite residents with same removed; center pied during meals/activitie reach of other reside services as indicated behaviors. On 09/21	g at items on dining room d, with interventions to d to: place at a table with diet; tablecloth will be ce removed; staff will monitor es; will not be seated within ents' food at meals; psych					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	ULTIPLE (CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185089	B. WIN				C 22/2010	
	ROVIDER OR SUPPLIER OD HEALTH CARE CEN		<u> </u>	550 l	FADDRESS, CITY, STATE, ZIP CODE HIGH ST. VLING GREEN, KY 42101	1 09/	22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 490	09/17/10 with a prob Behaviors of grabbin table, and at persons but not limited to: see have same diet; have hungry, needs assist remove objects from 09/21/10, the care plintervention to notify abnormal behaviors. The care plan for Re 09/20/10 with a prob Movements, Oral Fix in past, had taken fo trays and over eating but not limited to: more episodic chewing dustops feeding self at down if eating fast; rof abnormal behavior. The care plan for Re 09/16/10 with a prob Behaviors, at time un from edible and non food off others' trays but not limited to: placenterpieces; staff to not be seated within at meals.	sident #5 was revised on them of Inappropriate go objects, food on dining s, with interventions to include at at table with others who e snacks available when tance; reassure resident; table/tablecloth. On an was updated with an the nurse of any new sident #6 was revised on them of Repetitive action, does not currently, but not from others rooms or g, with interventions to include onitor all po intake; set up and ring meals; feed assist if meals; have resident slow notify nurse of any new onset ors and document. The sident #7 was revised on them of Socially Inappropriate nable to tell the difference redible item, history of taking s, with interventions to include acce at table without or monitor during meals; will reach of other residents' food	F	490				
	during meal service accordance with MD	rill continue to be served as appropriate and in o order for diet consistency. nechanically altered diets,						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	B. WIN	ıG		09/	C 22/2010
	OVIDER OR SUPPLIER	ITER		550 H	ADDRESS, CITY, STATE, ZIP CODE IIGH ST. /LING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	bread will be altered the meal service. Effective 09/17/10, r behaviors of reachir are not on their meal have been arranged residents with the sa altered diet. This is Seating Assignment Effective 09/02/10, emonitored by a licer the meal service. S report any identified licensed nurse. The responsible to cond residents during the behaviors or concerresponsible to docu identified concerns the 24-hour report a identified concerns Services and/or the CM will also review the previous 7-day exhibited behaviors identified and addrest that supervision is a DNS and CM partic dining room observision. Effective 09/17/10, is monitored by the of the meal service responsible to repoconcerns to the lice	esidents who have known ag for and obtaining items that al trays or that are inedible, to be seated at tables with ame MD ordered mechanically reflected on the Dining Room a Chart, effective 09/17/10. The licensed nurse is suct observations of all meal service to identify ans. The licensed nurse is ment any behaviors or on the Meal Supervision Log, and to report the behaviors or to the Director of Nursing Social Worker. The DNS and the Meal Supervision Logs for period to validate that and/or concerns have been assed on the care plans and appropriate. On addition, the ipate in the licensed staff attions to validate appropriate each activity with meal service Activities Staff for the duration	F	490			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	B. WIN	G		00	C /22/2010
	ROVIDER OR SUPPLIER	<u> </u>		ľ	ADDRESS, CITY, STATE, ZIP CODE		122,2010
11002110				BOV	VLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	Continued From pag	19 53	F	490			
1 -100	, 00,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		•	430			:
		s on the 24-hour Report and	1	İ			
		ors or identified concerns to		į			
	the DNS and/or Soc	al vvorker(Svv).					:
	: Effective 09/17/10	Administrative Licensed					i
		stant Director of Nursing		1			
		nit Manager (UM), Minimum	İ				
	1 7	or (MDSC), Case Manager					
		pervisor (WS) and Staff	ļ				1
		linator (SDC), participate in	1	!	•		
		ning room observations.		i			İ
		es through direct observations					!
		behaviors and/or concerns	İ				:
	have been identified	l, documented on the 24-Hour	!				:
	Reports and report	to the DNS and SW.	1				
	i Meal Supervision, b	ehaviors and/or concerns will					!
		each meal on the Meal		İ			
	Ł	The Meal Supervision Logs	İ				
		ly in the Stand-Up meeting					
		y the WS to identify any	ļ				
	:	idate that appropriate		1			
	corrective actions h	ave been taken. Any					
	concerns identified	will be documented on the		İ			
	Meal Supervision Lo	ogs at the time of the review.	!				İ
	All direct care staff	licensed nurses, and SRNAs	:				
		ed to report any and all	!				
	· ·	e wandering or reaching for		i			
		ood, and to document on the		Ì			
		id to address in care plans.					
	ĺ						
	Other Facility Resid	lents with the Potential to be	; ;				
		istered Dietician (RD) and		1			
		ervices Manager (ADSM)	İ				i I
	1	al records of all other facility inically altered diets on					

PRINTED: 10/06/2010 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OWR M	O. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185089	B. Wil	(G		09/	C 22/2010	
NAME OF PR	OVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
ROSEWO	OD HEALTH CARE CEN	TER			HIGH ST. VLING GREEN, KY 42101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ix	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 490	limited to: the compr Assessments, Comp Behavior and Mood I Notes. The 24-Hour Communication Bool Seating Arrangemen reviewed. Record re validate that all care appropriate and indic documentation. In a conducted through the identify residents with Comprehensive Care Nurse Aide Assignment Room Seating Arrang updated as indicated and staff interviews. To ensure the safety mechanically altered direct care staff, licer have been in-service behaviors, to include objects, to include objects, to include for educated to document the Resident Progress SRNAs were educated Behavior Logs and real The DNS and CM we interviews of licensed per unit) per week to exhibited and to valid	views included but were not ehensive MDS rehensive Care Plans, logs, and Resident Progress Report, The Dining Room and the Dining Room to Diagram were also views were conducted to plans were revised as lated based on addition, staff interviews were in-service offerings to a unreported behaviors. The element Plans, the State Registered ent Sheets and the Dining gement Diagram were, based on record reviews of all mobile residents on diets with behaviors, all lased nurses, and SRNAs d to report any and all wandering or reaching for oot. Licensed nurses were not the 24-Hour Reports, as Notes and on the Behavior on the care plans. The elect to document on the eport to the licensed nurse. Ill conduct 4 random staff d nurses and SRNAs (two identify any new behaviors date that all behaviors have eported and addressed on	F	490	DETIGIENOT			
		C, Case Manager (CM), and Jurse Practitioner (ARNP)						

CENTED	O FOR MEDICARE O	X MEDICAID SEKVICES				<u>Uivio i</u>	10. 0930-039 i
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	iultiple Ilding	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			ornes	TARRESS OF ATATE TO CORE	1 09/	/22/2010
	OD HEALTH CARE CE	NTER		550	T ADDRESS, CITY, STATE, ZIP CODE HIGH ST.		
			-	! 	WLING GREEN, KY 42101		
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F 490	Continued From pa	ge 55	F	490			:
	i	al records of all facility	1				
	i .	10. Record reviews included	:				
	i .	e MDS Assessments,	ĺ				i
	i ·	re Plans, Behavior and Mood Progress Notes for the					
	1 7	riod. Record reviews were	i	j			
		te that all care plans were	1	İ			
	į.	ate and indicated based on	İ				
	documentation. In	addition, staff interviews were					
		the in-service offerings to					
		ith unreported behaviors. The					
	i ·	e plans, SRNA Assignment	!				İ
		Room Seating Arrangement	!	į			
	∣ Diagram were upda I record reviews and	ited, as indicated, based on	İ				
	Tecord reviews alsu	stan interviews.					
	In addition, on 09/2	1/10, all SRNA Assignment					
		ed to reflect the intervention for					
		and all new behaviors to the	į				
	licensed nurse.						
	Systemic Changes Deficient Practice:	to Prevent Reoccurrence of	:				
	The DNS, UMS and	d Weekend Supervisor	!				į
		to all direct care staff, to	į				
	include licensed nu	rses and SRNAs on 09/17/10.	;				
	In-service content in	ncluded care plans and care					
	plan meetings and a						
		ddition, all direct care staff,					
		were educated on the Dining					
		gnment Chart and on how the					
		. All staff were educated that ups will be the same as the	i				
		ng Assignment Chart.	!				
	The DO and DDCO	initiated investigative Training					
		8/10 with the ED and DNS.	ļ				
		led in-servicing to all					İ

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE LDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185089	B. WI	IG		09/22	2/2010	
	OVIDER OR SUPPLIER	TER		550	T ADDRESS, CITY, STATE, ZIP CODE HIGH ST. WLING GREEN, KY 42101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 490	Social Worker, UM, F Housekeeping Super Program Director, Nu ARNP and Respirato In-service content inc Resident Health State Documenting in a Re 24-Hour Reports and The DNS and UM init on 09/21/10 with all d licensed nurses, SRN related to meal super In-servicing was initia 09/20/10 and will con staff have attended th Staff will not be allow attended the appropr in-service will be inclu Orientation for all nev utilize Agency Staff, Agency Staff, they wi to working. The ED and DNS will that staff do not work in-service. A sign is notify staff they are n any resident prior to a to receive the in-serv in-service is a charge a charge nurse on a Facility Monitoring: An ad hoc Performan	ED, DNS, CM, MDSC, RD, Activity Director, visor, Rehab Manager, trition Services Manager, ry Therapist) on 09/20/10. Studed Documentation of us, Needs and Services; sident's Medical Record; Investigative Protocol. Itiated additional in-servicing lirect care staff to include IAs, and Activities staff vision. Inted on 09/17/10 and tinue until all appropriate in-service, and to work until having liate in-service. The unded in New Employee whires. The facility does not lif the facility should employ II receive the in-service prior to receiving the posted at the time clock to out to work or provide care to reporting to a charge nurse lice. If the staff in need of a nurse, they are to report to	F	490				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	TER .		550	ET ADDRESS, CITY, STATE, ZIP CODE HIGH ST. WLING GREEN, KY 42101		
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F 490	The Medical Director Action Plan on 09/20/20 The ED, DNS, RD an mechanically altered interviews, direct obs and through record re Mood Logs and Residence will also including and Dietary Cor DNS, RD and WS will week for four weeks.	S, UM and RD. was notified of the Facility 10. d WS will audit residents on	F	490			
	(two per unit) per wee exhibited and to valid been appropriately accomprehensive care include but not be lim Assessments, Comprehensive and Mood L Notes for the previous and CM will also revious exhibited behaviors a identified and address and CM participate in room observations. In addition, the audits interviews of licensed per unit) per week to exhibited and to valid	plans. The audits will ited to: the MDS rehensive Care Plans, logs and Resident Progress s 7-day period. The DNS ew the meal Supervision 7-day period to validate that nd/or concerns have been sed. In addition, the DNS the licensed staff dining s will include 4 random staff incress and SRNAs (two identify any new behaviors ate that all behaviors have ported and addressed on					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	B. WIN	IG		C 09/22/2010	
	ROVIDER OR SUPPLIER OD HEALTH CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
1 430	(residents on mechar behaviors, and the M findings at the weekly meet weekly (Tuesda	onsible to report all audit		490			
	action steps. If no concerns are ide (Tuesday) PIC meetil	entified during the weekly ngs, the audits will take asis for two months, and on					
	findings at the month findings will be review validate that any iden immediately corrected	ponsible to report all audit ly PIC meeting. All monthly wed at the monthly PIC to stified concerns were d. Findings will be tracked C for additional action steps,					
	limited to, (ED, DNS, DM, Activities Director events during mornin Event Reports, 24-Ho Dietary Communication events are investigated and overall we maintained for the affiresidents with the potents.	fected resident, other facility tential to be affected, to systemic changes and to					
	through attendance a	e for overall compliance It the Stand -Up Meetings lits to ensure they were will assume overall					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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		185089				09/22/2010	
	OVIDER OR SUPPLIER OD HEALTH CARE CEN	FER		5	REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X6) COMPLETION DATE
F 490	Program at the Facilit The ED will utilize we recommendations to (from resident identification of Compliance. The Irreturn to routine monieach month as specific Performance Improve when substantial commendation of Compliance. The Irreturn to routine monieach month as specification of Compliance. Improve when substantial commendation of Irreturn to routine monie each month as specific Performance Improve when substantial commendation. In addition, the DDCC with the facility to review to validate that investigated, to include the validate that investigated, to include extended survey, with staff (Social Worker # LPN #6, CNA #11, CNA #1 revealed there was not dining room. Resider residents on the same staff were present in the administrative start of the staff in the distaff then documented in the dining room and the staff then documented in the dining room and	Performance Improvement y. ekly (Wednesday) IDT validate one medical record ed in the IDT Meeting) to on of the Credible Allegation ED/Administrator will then toring, of the facility systems ied in the Facility ement policy and procedure, upliance is achieved. O will conduct weekly calls lew events from the previous all events are thoroughly fe care plan revisions. on 09/22/10, during the on the DON and direct care 12, RN #1, RN #3, LPN #2, IV #8, CNA #3, CNA #5, CNA #13, CNA #14 and CNA #15), but seating chart for the nets were seated with the diet consistency. Licensed the dining room for all meals aff participated in the dining revealed if any behaviors reported the behavior to the lining room. The licensed of them on the behavior logs deported them to the cumented them on the 24	F	490			
	revealed Resident #1	on meal, on 09/22/10, was seated at a table by was placed on the table until					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(((2)))	111 710	NE COMPTONOTION		<u> </u>	
	CORRECTION	IDENTIFICATION NUMBER:	- 1		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF DE	ROVIDER OR SUPPLIER	10000		Ι		09	9/22/2010	
TOTAL OF T	TO VIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
ROSEWO	OD HEALTH CARE CEN	TER			50 HIGH ST.			
	i			В	OWLING GREEN, KY 42101			
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		·			DEFICIENCY)	NOT NOTICE		
F 490	Continued From page	- 60	-	400				
			· F	490				
	Resident #1's tray wa	is served. The CNA	!					
	the trouwer conted	n next to the resident when	:				j	
		Residents #4, #5, #6 and #7						
		dents with like diets and	1	į			!	
	chart A liconcod etc.	ng to the dining room seating If was present during the		í			i	
	entire meal Staff wa	re reporting observations of					:	
	behaviors to the licen	sed staff during the meal. A	į					
	review of the Dining F	Room behavior observation						
	sheet for 09/22/10 rev	vealed each resident's name	:	ļ			i	
	was documented with	the behaviors that was						
		ons of Resident #1 on		į			1	
		the day) revealed the		i			!	
	resident was in a whe	elchair sitting in the area						
		e's station, in view of staff.	1					
			İ					
		s' #1, #4, #5, #6 and #7		İ				
	comprehensive care	plan revisions, revealed the	į					
	care plans had been			i				
	individualized interver	ntions for each resident, to	İ	- !				
		elated to the residents'	:	į			i	
;	behaviors of grabbing	food/drinks.	:	ŀ			:	
	Reviewe of the in ac-	vice training provided to the	i					
	direct care staff, date	vice training provided to all	i	ļ				
	09/19/10 and 09/21/1			1			İ	
		are plans and care plan					İ	
ĺ	meetings assigned of	eating charts, dining/meal					i	
	service supervision a	ectivity seating groups, to					!	
		naviors (to include wandering					:	
	or reaching for objects	s to include food/drink) and					!	
,	documentation. In ad	dition, Administrative Staff					!	
	were in-serviced on [Documentation.		İ				
	Documenting the Res						j	
	Needs and Services,	Documenting in a						
	Resident's Medical Re	ecord and on the 24- Hour						
		The Executive Director and		į				
		icing on 09/18/10 related to						
	conducting investigati		i					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mt	ILTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDFLANO	CONNECTION		A. BUIL	DING	And the second s	С	
		185089	B. WIN	3		09/22/2010	
	OVIDER OR SUPPLIER	NTER	And the second s	550	ET ADDRESS, CITY, STATE, ZIP CODE HIGH ST. WLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPI	(5) LETION ATE
F 490 F 514 SS=K	Although it was deted Jeopardy was remonon-compliance conseverity of a "D", bar monitor for the on-gorrective actions to through the facility's 483.75(I)(1) RES RECORDS-COMPLE		514	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.			
	resident in accordar standards and pract accurately document systematically orga. The clinical record information to ident resident's assessm services provided; the preadmission screet and progress notes. This REQUIREMENT by: Based on observation review, it was determined according to the preadmission of the preadmission screet and progress notes.	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record		and the second s	F 514 On 09/07/10, the care plan wareflect dining room seating arr Resident #1. On 09/16/10, the updated to reflect a problem of Choking Possible Aspiration of Dementia with Impulsive Behabehavior of Grabbing food and with interventions to include be to: provide LCS pureed diet wilquids by small spoon per star po intake and po fluids, fed per encourage dining room attended and sit with residents wild diet; supervise all po intake arron 09/21/10, the care plan war a problem of no safety awarer resident grabs out for people and sit with residents.	angements for care plan was f At risk for elated to avior , Past d/or liquids, ut not limited ith honey thick ff; encourage or staff; lance each th same texture as updated, with ness as the	
	Based on observations, interviews and record review, it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented, with sufficient information regarding resident assessments related to problem behaviors and development and implementation of care plan interventions needed for adequate supervision for five residents (#1, #4, #5, #6 and #7), in the selected sample of five. Additionally, the facility				resident grabs out for people a interventions to include but no keep the resident in a superviout of the bed; notify the nurse abnormal behavior, be attentive resident when reaching; and cresident to attend activities. The care plan for Resident #4 09/17/10 with a problem of Inc.	ot limited to: sed area when e of any ve to the encourage the was revised on	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	water and the control of the control	į
		185089	B. WIN	IG		C 09/22/2010
NAME OF PR	ROVIDER OR SUPPLIER			l	ET ADDRESS, CITY, STATE, ZIP CODE 0 HIGH ST.	
ROSEWO	OD HEALTH CARE CEN	TER			OWLING GREEN, KY 42101	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 514	information for each Staff interviews and it Resident #1 was idea for choking and receive consistency. However, aware Resident #1 in grabbing food and flut from the dining table consistency ordered no evidence the known documented or inclured plan with intervention implemented to ensuradequately supervised. On 09/01/10, Reside resident obtained from by staff. The resider no pulse. Staff were at the facility and Em	tablished policy and o documentation of the resident. record review revealed ntified by the facility as at risk lived a specialized diet er, the facility staff was ad exhibited behaviors of uids from other residents or which was not the for the resident. There was lived in the resident's care as developed and live Resident #1 was led during eating. Int #1 choked on bread the live and plate placed on the table at stopped breathing and had livergency Medical Services	F	514	This Plan of Correction is the center allegation of compliance. Preparation and/or execution of this does not constitute admission or agree provider of the truth of the facts alle set forth in the statement of deficience correction is prepared and/or executive is required by the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of feet and the provisions of grabbing objects allegation of the provisions of grabbing objects. The care plan for Resident #5 09/17/10 with a problem of Inc. Behaviors of grabbing objects.	plan of correction eement by the ged or conclusions ries. The plan of led solely because eleral and state law. s on dining ith t limited to: with same diet; nter piece ing ated within at meals; r management e care plan was o notify the enaviors. was revised on appropriate , food on dining
	responded and had to insert a Laryngoscope (instrument inserted into the resident's airway to remove the bread with forceps.) The resident was transported to the hospital.	into the resident's airway to the forceps.) The resident	:	:	table, and at persons, with into include but not limited to: seal others who have same diet; h available when hungry, needs reassure resident; remove obj	at table with ave snacks assistance;
	incident, the facility f	d reviews revealed after the ailed to correct the lack of haviors for Residents #1, #4,	table/tablecloth. On 09/21/10, a lack of was updated with an interven		the care plan ion to notify the phaviors. was revised on	
	that were complete a risk for choking, repr caused and was like harm, impairment or	to maintain clinical records and accurate for residents at resented a situation that had ly to cause serious injury, death to a resident.			Movements, Oral Fixation, do currently, but in past, had take others rooms or trays and ove interventions to include but no monitor all po intake; set up a chewing during meals; feed a feeding self at meals; have re	es not en food from er eating, with of limited to: nd episodic ssist if stops

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED				
AND PLAN OF	CORRECTION	IDENTICATION NORDER.	A. BUI	LDING		c
		185089	B. WIN			09/22/2010
	OVIDER OR SUPPLIER	TER		550	ET ADDRESS, CITY, STATE, ZIP CODE) HIGH ST.	
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F 514	514 Continued From page 63 F 514					
	and was found to exist on 09/01/10 and was on-going. Substandard Quality of Care was			!	This Plan of Correction is the center allegation of compliance.	r's credible
	identified at 483.25 C	Quality of Care. The facility 1/10. Findings include:	:		Preparation and/or execution of the does not constitute admission or ag provider of the truth of the facts all	reement by the eged or conclusions
	Documenting in a Red dated 10/31/09, reve	ly's policy and procedure for esident's Medical Record, ealed the medical record	:		set forth in the statement of deficier correction is prepared and/or exec it is required by the provisions of fo	uted solely because
	should serve as a planning tool for resident care, to record the course of the resident's treatment and changes in medical condition and to				down if eating fast; sit out of a other trays; notify nurse of ar abnormal behaviors and doc	y new onset of
	document communic members.	cation between the healthcare		!	plan for Resident #7 was rev with a problem of Socially Ina Behaviors, at time unable to	ised on 09/16/10 appropriate
	1. Record review rev	vealed Resident #1 was ty with diagnoses to include			difference from edible and no history of taking food off other	on-edible item, ers' trays, with
	Dementia, Diabetes Vascular Accident.	Mellitis and Cerebral	:		interventions to include but n place at table without centery monitor during meals; will no	pieces; staff to : t be seated
	3:50 PM, Registered	Activity Director on 09/17/10 at 1 Nurse (RN) #1 on 09/17/10	:	:	within reach of other residen at meals.	
	Licensed Practical Nat 5:20 PM, LPN #2	on 09/16/10 at 2:40 PM, Nurse (LPN) #1 on 09/16/10 2 on 09/17/10 at 1:40 PM, LPN	:		The DNS, UM, Registered D Assistant Dletary Services M reviewed the medical record	lanager (ADSM)
	at 3:00 PM. Certifie	0:55 AM, LPN #4 on 09/17/10 d Nurse Aide (CNA) #1 on	; ; !	!	facility residents on mechani diets on 09/19/10. Record re	cally altered views included
	09/16/10 at 2:55 PM, CNA #2 on 09/16/10 at 3:20 PM, CNA #3 on 09/16/10 at 3:10 PM, CNA #4 on 09/16/10 at 3:10 PM, CNA #5 on 09/16/10 at 5:05 PM, CNA #6 on 09/16/10 at 5:15 PM, CNA #7 on 09/16/10 at 5:35 PM, CNA #8 on 09/16/10			!	but were not limited to: the c MDS Assessments, Compre Plans, Behavior and Mood L	hensive Care
			!	:	Resident Progress Notes. The Report, The Dining Room Company of the Progress Notes.	ne 24-Hour ommunication
	CNA #10 on 09/16/	on 09/16/10 at 2:40 PM and 10 at 4:05 PM, revealed	:	•	Book and the Dining Room S Arrangement Diagram were Record reviews were condu	atso reviewed.
	and/or fluids off of re	haviors of grabbing food esidents' trays and from the rior to 09/01/10. The staff	:		that all care plans were revis	sed as ased on
	stated they immedia	ately took the food/fluid away he staff revealed they tried to			documentation. In addition, were conducted through the	staff interviews in-service
	keep an eye on the	resident because of the			offerings to identify resident behaviors. The Comprehense	s with unreported sive Care Plans.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER OD HEALTH CARE CE	NTER	550	ET ADDRESS, CITY, STATE, ZIP COD) HIGH ST.) WLING GREEN, KY 42101	E
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION E APPROPRIATE DATE
F 514	from tables and oth stated everyone was this behavior becautime. However, revealed care Plan revealed care plan to address grabbing other resisterom the table. Interviews on 09/17/09/20/10 at 10:50 A (MDS) Supervisor, Worker #1 (who papalan meetings), revealed and other the behavior should the record or broug meeting so the behaddressed in the record or broug meeting so the behaddressed in the record or broug meeting so the behaddressed in the record or broug meeting so the behaddressed in the record or broug meeting so the behaddressed in the record or broug meeting so the behaddressed in the record or broug meeting so the behaddressed in the record or 09/16/10 at 3:40 PM, CNA #2 on 09 09/16/10 at 3:10 PM, CNA #9 on 09 #10 on 09/16/10 at #1 was seated at a dining room with other meal on 09/01/10. fresh baked bread to the residents whistaff revealed they residents at the first revealed as she turobserved Residents.	s of grabbing food and drinks er residents' trays. They as aware that Resident #1 had use the resident did it all the riew of the Comprehensive there was no revision to the s the resident's behavior of dent's food off the trays or 7/10 at 3:00 PM and on amount of the supervisor and Social ricipated in the resident's care ealed they were not aware chaviors of grabbing food from residents' trays. They stated that have been documented in the py staff in the care plan avior could have been	F 514	This Plan of Correction is the allegation of compliance. Preparation and/or execution does not constitute admission provider of the truth of the fact set forth in the statement of decorrection is prepared and/or it is required by the provisions. The State Registered Nurseless and the Dining Roarrangement Diagram we indicated, based on recording to the interviews. In addition, or Assignment Sheets were the intervention for staff for new behaviors to the lices. The DNS, UMS and Wee initiated in-servicing to all include licensed nurses a 09/17/10. In-service controlled plans and care plan meeting and care plan meeting and care plan meeting and report to the licensed nurses were also educated the 24-Hour Reports, the Notes and on the Behavitaddress on the care plan educated to document or and report to the licensed nurse been in-serviced to report behaviors, to include war for objects, to include war for objects, to include war for objects, to include for on the 24-Hour Reports a care plans. Administrative direct observations will visibehaviors and/or concernidentified, documented on Reports and report to the DDCO completed in-servations will visibehaviors.	of this plan of correction or agreement by the is alleged or conclusions ficiencies. The plan of executed solely because of federal and state law. See Aide Assignment from Seating ore updated as in direct care staff, to ind SRNAs on ent included care tings. Licensed ed to document on Resident Progress or Logs and to s. The SRNAs were in the Behavior Logs in urse. All direct care, and SRNAs have it any and all indering or reaching indicate that all insended to address in the indicate that all insended that all insended sold. The indicate that all insended in the 24-Hour in DNS and SW. The vicing to all DNS, CM, MDSC,

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) Mi	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	with him/her. CNA at the resident and rem hand and from the to out trays. The staff knew CNA #4 shout blue. The staff state Code, grabbed a craresident to the floor. responded to the collection of the collection of the collection of the staff state collection. The resident to the floor responded to the collection of the staff state collection. The resident transposed is the staff was in passing fluids to the Resident #1 when the served and stayed resident staff was in passing fluids to the Resident #1 when the served and stayed resident his/her me passing out the resident passing the transposed a resident resident's fluids.	n a resident sitting at the table 49 stated she walked over to soved the bread from his/her table. She resumed passing revealed the next thing they ed Resident #1 was turning at they immediately called a sish cart and lowered the The licensed staff de and attempted the with finger sweeps three ss. They stated the resident and they could not detect a liled and Cardiopulmonary) was started. A review of the	F	Preparation and/does not constitute provider of the traset forth in the stacorrection is prepit is required by the Housekeeping Program Direct Manager, ARN on 09/20/10. In Documentation Needs and Ser Resident's Mediand Investigation The DNS and records (two pubehaviors exhibehavior have on the comprewill include but Assessments, Behavior and Progress Note period. The DN meal Supervisiperiod to validate and/or concernaddressed. In 4 random staff and SRNAs (hidentify any new validate that a appropriately recomprehensive The DNS will the set of th	or execution of this plan of correction endmission or agreement by the path of the facts alleged or conclusions tement of deficiencies. The plan of ared and/or executed solely because the provisions of federal and state law. Supervisor, Rehab Manager, or, Nutrition Services P and Respiratory Therapist) In-service content included of Resident Health Status, vices; Documenting in a dical Record; 24-Hour Reports we Protocol. CM will audit four random the runit of the validate that all been appropriately addressed then appropriately addressed then appropriately addressed then appropriately addressed then appropriately addressed then appropriately addressed then appropriately addressed then appropriately addressed then appropriately addressed then appropriately addressed then appropriately addressed then appropriately addressed the story of the previous 7-day. It is for the previous 7-day. It is for the previous 7-day and that exhibited behaviors as have been identified and addition, the audits will include interviews of licensed nurses we per unit) per week to we behaviors exhibited and to I behaviors have been eported and addressed on the eresponsible to report all
	Resident #1 reveal	ed the resident's care plan was		audit (resident	s on mechanically altered

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				1 01110	. 0000 0001
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F 514	Continued From pag	e 66	F	51	4		
, 0, ,	This Plan of		This Plan of Correction is the cen-	ter's credible			
		tency on 09/07/10; however,	!		allegation of compliance.		
		ons to the care plan to			Preparation and/or execution of ti	his plan of correction	,
		upervision/monitoring of the	İ		does not constitute admission or a		Ì
		ehavior of grabbing of			provider of the truth of the facts a	lleged or conclusion	s
	food/drinks and the i	ncreased risk of the resident			set forth in the statement of deficie	encies. The plan of	
		ere no interventions to			correction is prepared and/or execute it is required by the provisions of		
		nt the resident's behavior of			it is required by the provisions by	1	
	grabbing food/drinks	i.			diets, behaviors, and the Me	al Supervision	
					Logs) findings at the weekly	PIC meeting.	
		evealed Resident #4 was	i		The PIC will meet weekly (T	uesday) for four:	
	admitted to the facili	ty with diagnoses to include	:		weeks to review audit finding	gs to determine	
	Alzheimer's Disease				need for additional action st	eps. If no	:
			1		concerns are identified during	ng the weekly	
		2 on 09/16/10 at 5:40 PM,			(Tuesday) PIC meetings, the		
	RN #1 on 09/16/10 a	at 2:40 PM, LPN #1 on			place on a monthly basis for on an as needed basis there		
	09/16/10 at 5:20 PM	, CNA #5 on 09/16/10 at 5:05			will be responsible to report		
		16/10 at 5:15 PM, CNA #7 on	-		at the monthly PIC meeting.		ì
		and CNA #8 on 09/16/10 at			findings will be reviewed at	the monthly PIC	j l
	5:50 PM, revealed h	Resident #4 grabbed other sor pulled the tablecloth to	!		to validate that any identified		
	residents 1000/0111K	her reach. However, further	:		immediately corrected. Find	ings will be	
		al record revealed there was			tracked and trended at the F	기C for additiona	!
		f the resident's behaviors of			action steps, if indicated. Th	ie ED will utilize	
		and pulling the tablecloth to			weekly (Wednesday) IDT re		
	pull items within rea		-		to validate one medical reco identified in the IDT Meeting		H. I
ĺ	f				implementation of the Credi	ble Allegation	
	Observation of the r	noon meal on 09/16/10 at			of Compliance. The ED/Adr	ninistrator will	1
	12:15 PM, revealed	Resident #4 was seated at a			then return to routine monitor		ļ
	table with a resident	with the same kind of diet. A			facility systems each month	as specified in	Completion
		the dining room. A CNA sat	1		the Facility Performance Im	provement policy	y date 9/23/1
	with Resident #4 wh	nen his/her tray was served.	ļ		and procedure, when substite is achieved.	antial compliance	ė
	A review of the com	prehensive care plan for			is acineved.		
		on in nutrition/hydration	į				
	related to mechanic	ally altered diet, end stage					
	Alzheimer's and not	ential for aspiration, dated					
	08/04/10_revealed	interventions to provide a			:		
		with pectar thick liquids, fed	!		· I		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<u> </u>	TIPLE CONSTRUCTION	(X3) DATE S COMPL	
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RUSEWO	OD HEALTH OAKE OEK			BOWLING GREEN, KY 42101		
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F 514	Continued From pag	e 67	F 51	14		
1 011	• -	om and encourage to eat				-
	slowly Further revie	w revealed the care plan did				į
	not address adequal	e supervision/monitoring of	į			
	the resident's behav	iors of grabbing food/drinks				
	and pulling the table	cloth to pull items within		 		
		ionally, there were no	İ			:
		itor and document the				
		of grabbing food/drinks.				
	3. A record review r	evealed Resident #5 was				; ·
		ty with diagnoses of Late		i e		
	Effect Cerebral Vaso	cular Accident (CVA) and				
	. Vascular Dementia.		i			1
	An interview with CN	IA #5 on 09/16/10 at 5:05		:		:
		ent #5 was blind in one eye	!			:
	and saw objects with	n the other eye and grabbed		i		
	for them. She state	d the resident had grabbed	:	!		:
	food/drinks belonging	g to another resident in the		1		!
	dining room. Howev	ver, further review of the				
		documentation of the	į			
		of grabbing for food/drinks in	i !	;		!
	the dining room.					:
		and analysis sare also for	1	 		į.
		prehensive care plan for				:
		n/hydration related to d diet and swallowing	:	i		•
	problems, dated 03/		:	<u>'</u>		1
	intervention to provi	de assistance with meals.		•		
	: Further review reve	aled the care plan did not				
	address adequate s	upervision/monitoring of the	:			
	resident's behavior	of grabbing food/drinks and	:	:		
	there were no interv	rentions to monitor and				
	document the reside	ent's behavior of grabbing		į		
	food/drinks.					į
			:			
		revealed Resident #6 was	:	;		•
	admitted to the facil	ity with diagnoses of	;			
	Alzheimer's Diseas	9 .				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	B. WIN	ıG		09/2	2/2010
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F 514	Continued From pag	e 68	F	514			
	PM, revealed Reside residents' food/drink the dining room. Ho medical record reve	s at times when he/she ate in wever, further review of the aled there was no e resident's behavior of					
	impaired swallowing too fast causing him interventions to proving liquids and to encoudown and take smalchoking. Further redid not address ade of the resident's belfood/drinks and their	prehensive care plan for a related to the resident ate //her to choke revealed //her to choke revealed //her to choke revealed //her to choke revealed with regular rage the resident to slow all bites to decrease the risk of view revealed the care plan requate supervision/monitoring revere no interventions to ent the resident's behavior of s.					
	admitted to the faci Disorder.	revealed Resident #7 was lity with diagnoses of Mental					
	revealed Resident food/drinks at times objects. However,	PN #1 on 09/16/10 at 5:20 PM, #7 grabbed other residents' and tried to eat inedible further review of the medical ere was no documentation of vior of grabbing for					
	risk for altered nutr Alzheimer's and wa revealed an interve	nprehensive care plan for at ition/hydration related to andering, dated 03/11/10, antion to provide a mechanical ad meat and regular liquids.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER OD HEALTH CARE CEN	ITER		550 H	r ADDRESS, CITY, STATE, ZIP CODE HIGH ST.		
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F 514	Continued From pag	F	514			İ	
	address adequate st resident's behavior of and there were no in	aled the care plan did not upervision/monitoring of the of grabbing for food/drinks network to monitor and ent's behavior of grabbing for					
	PM, revealed during #1's incident, she di four other residents had behaviors of grafood/drinks. She had no documentation in records identifying the food/drinks, no care behaviors and no in	e DON on 09/20/10 at 1:25 If the investigation of Resident Id not identify that there were If (#4, #5, #6 and #7), who also In a subbing for other residents' In the residents' medical In the behaviors of grabbing for In plans to address the Iterventions to monitor and Iteritation of grabbing					
	the removal of the I received on 09/22/1 was verified remove The alleged date of Based on observati	ible allegation of correction for mmediate Jeopardy was 10. The Immediate Jeopardy ed on 09/22/10, prior to exit. Tremoval was 09/22/10. ons, interviews and record was made the Immediate oved on 09/22/10.					
	The AOC revealed:		:				
	Affected residents:						:
	direct care staff, lice Nurse Aides, that F the dining room at	RNP communicated to all ensed nurses State Registered Resident #1 would be seated in a table with other residents ame type of mechanically					

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	'	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL	ETED
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		185089				09/22/2010	
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
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			i	<u> </u>	PROVIDER'S PLAN OF CORE	RECTION	; (X5)
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F 514	Continued From pag	e 70	F	514			
	O. 00/07/40 the com	a nian was undated to reflect			1		
İ	Un 09/07/10, the car	e plan was updated to reflect arrangement for Resident #1.					:
	On 00/16/10 the car	e plan was updated to reflect					
	a problem of At risk	for Choking Possible	!				:
	Aspiration related to	Dementia with Impulsive					
	Behavior . Past Beh	avior of Grabbing food and/or					1
		tions to include, but not					
	limited to: provide LC	CS pureed diet with honey	!				į.
		l spoon per staff; encourage					
		ds, fed per staff; encourage					
		nce each meal and sit with					
		exture diet; supervise all po					
		es. On 09/21/10, the care					Ì
		vith a problem of no safety ent grabs out for people and					
	itome with intervent	ions to include, but not limited	l.				
		supervised area when out of			 		
	hed: notify nurse of	any abnormal behavior; be					
		when reaching; and	i				
	encourage resident	-					!
	In addition, the Exec	cutive Director (ED), Director					
	of Nursing Services	(DNS), the District Director of					1
		nd the District Director of					
		(DDCO), conducted further					:
		sident #1 on 09/19/10. This					
		ted of staff interviews and					
		ew, to include but not limited			İ		
	to: the comprehens	ive Minimum Data Set (MDS)					
1	Assessment, Resid	ent Assessment Protocols					
	(KAPS), Comprehe	nsive Care Plan, Behavior and sident Progress Notes. The					
		Dining Room Communication					
	Rock and the Dining	g Room Seating Arrangement	İ				
	Diagram were also	reviewed. The SRNA	!				İ
	Assignment Sheet	and the Dining Room Seating					
	Arrangement Diagra	am were updated for Resident					
	#1.	***** ****					

PRINTED: 10/06/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С B. WING 185089 09/22/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 550 HIGH ST. **ROSEWOOD HEALTH CARE CENTER BOWLING GREEN, KY 42101** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 71 F 514 F 514 The care plan for Resident #4 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing at items on dining room tables, including food, with interventions to include, but not limited to: place at table with residents with same diet; table cloth will be removed; center piece removed; staff will monitor during meals/activities; will not be seated within reach of other residents' food at meals; psych services as indicated for management of behaviors. On 09/21/10, the care plan was updated with an intervention to notify nurse of any new abnormal behaviors. The care plan for Resident #5 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing objects, food on dining table, and at persons, with interventions to include, but not limited to: sitting at table with others who have same diet; have snacks available when hungry, needs assistance; reassure resident; remove objects from table/tablecloth. On 09/21/10, the care plan was updated with an intervention to notify nurse of any new abnormal behaviors. The care plan for Resident #6 was revised on 09/20/10 with a problem of Repetitive Movements, Oral Fixation, does not currently, but

in past, has taken food from others rooms or trays and over eating, with interventions to include, but not limited to: monitor all po intake; set up and episodic chewing during meals; feed assist if stops feeding self at meals; have resident slow down if eating fast; notify nurse of any new onset of abnormal behaviors and document.

The care plan for Resident #7 was revised on

ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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F 514	09/16/10 with a prob	lem of Socially Inappropriate	F	514			
	from edible and non food off others' trays but not limited to: pl centerpleces: staff to	nable to tell the difference -edible item, history of taking s, with interventions to include, ace at table without o monitor during meals; will n reach of other residents' food					
	during meal service accordance with MI For residents with r	would continue to be served as appropriate and in D order for diet consistency. mechanically altered diets, ared accordingly and served ce.					! ! ! !
	behaviors of reach are not on their me have been arrange same MD ordered	residents who have known ing for and obtaining items that all tray or that are inedible, do to be seated at tables with mechanically altered diet. This Dining Room Seating effective 09/17/10.					
	monitored by a lice the meal service. report any identifie licensed nurse. The responsible to con	each meal service will be ensed nurse for the duration of SRNAs are responsible to debehaviors or concerns to the licensed nurse are duct observations of all					
	behaviors or conc responsible to doc identified concern the 24-hour report identified concern Services and/or the	ne meal service to identify erns. The licensed nurse are cument any behaviors or s on the Meal Supervision Log, t and will report the behaviors or s to the Director of Nursing ne Social Worker. The DNS and w the Meal Supervision Logs for					

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F 514	Continued From pag	e 73	F	514			
	exhibited behaviors a and addressed on the supervision is appropriate and CM participate in room observation to supervision. Effective 09/17/10, expension is monitored by the	and/or concerns are identified the care plan and that priate. In addition, the DNS in the licensed staff dining validate appropriate ach activity with meal service Activities Staff for the duration Activities Staff are at any identified behaviors or insed nurse. The licensed at document any behaviors as on the 24-hour Report and are or identified concerns to					
	Nurses (DNS, Assis Services (ADNS), U Data Set Coordinate (CM), Weekend Suppression of ticensed staff dining Administrative nurse will validate that all have been identified Report and report to Meal Supervision, be documented at a Supervision Log. The reviewed daily in weekends by the W to validate that appression taken. Any contents of the coordinate	es through direct observation behaviors and/or concerns d, documented on the 24-Hour					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER OD HEALTH CARE CEN	rer		5	REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
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F 514	All direct care staff, licer have been in-service behaviors, to include objects, to include for 24-Hour Report and 19 Other Facility Reside Affected: The DNS, UM, Regist Assistant Dietary Serviewed the medical residents on mechan 09/19/10. Record relimited to, the comprescomprehensive Care Logs, and Resident F24-Hour Report, The Communication Book Seating Arrangement reviewed. Record revalidate that all care appropriate and indicated through the identify residents with Comprehensive Care Nurse Aide Assignment Room Seating Arrangupdated as indicated staff interviews. To ensure the safety mechanically altered direct care staff, licer have been in-service behaviors, to include objects, to include for the safety of the saf	censed nurses, and SRNAs d to report any and all wandering or reaching for od, and to document on the o address in care plan. Ints with the Potential to be tered Dietician (RD) and vices Manager (ADSM) records of all other facility ically altered diets on views included, but not phensive MDS Assessment, Plan, Behavior and Mood Progress Notes. The Dining Room and the Dining Room t Diagram were also view was conducted to plans were revised as	F	514			

PRINTED: 10/06/2010 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		IPLE CONSTRUCTION	(X3) DATE COMP	
		185089	B, WING		0:	C 9/22/2010	
NAME OF PR	OVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP COD		
ROSEWOOD HEALTH CARE CENTER			1	550 HIGH ST. BOWLING GREEN, KY 42101			
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F 514	Log and to address of were educated to do and report to the licer. CM will conduct 4 railicensed nurses and week to identify any to validate that all be appropriately reported comprehensive care. The DNS, UM, Minin (MDSC), Case Mana Register Nurse Practical records of all 09/21/10. Record relimited to: the MDS A Care Plan, Behavior Resident Progress Nurse Practical records of all care plans we and indicated based addition, staff interviet the in-service offerin unreported behavior plan, SRNA Assignm Seating Arrangement indicated, based on interviews. In addition, on 09/21 Sheets were update staff to report any ar licensed nurse. Systemic Changes to Deficient Practice:	otes and on the Behavior on the care plan. The SRNAs cument on the Behavior Log nsed nurse. The DNS and indom staff interviews of SRNAs (two per unit) per new behaviors exhibited and haviors have been d and addressed on the plan. The Data Set Coordinator ager (CM), and Advanced ditioner (ARNP) reviewed the life facility residents on views included but were not assessment, Comprehensive and Mood Logs and lotes for the previous 30-day awas conducted to validate are revised as appropriate on documentation. In a lows were conducted through gs to identify residents with s. The comprehensive care nent Sheet and Dining Room at Diagram were updated, as record review and staff 1/10, all SRNA Assignment do to reflect the intervention for and all new behaviors to the	F	: 514	4		
	THE DING, UING and	Weekend Supervisor					

Facility ID: 100410

CENTER	S FUR WEUICARE &	VIEDICAID SERVICES				<u> </u>	7
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 514	Continued From page		F	514			
F 514	include licensed nurs In-service content inc plan Meeting and Ass In addition, all direct Activities, were educed Seating Assignment was designed. All stractivity seating group Dining Room Seating The DO and DDCO in-servicing on 09/18. The DDCO complete Administrative Staff (Social Worker, UM, February Housekeeping Super Program Director, Not ARNP and Respirated In-service content inc Resident Health State Documenting in a Resident Health State Documenting in a Resident Health State Documenting in a Resident Health State Documenting in a Resident Health State Documenting in a Resident Health State Documenting in a Resident Health State Documenting in a Resident Health State Documenting in a Resident Health State Documenting in a Resident Health State Documenting in a Resident Health State Documenting was initionally 109/20/10 and will constaff have attended to staff will not be allow attended the appropriate content in the DNS and UM	o all direct care staff, to es and SRNAs on 09/17/10. cluded Care plans and Care signed Seating Designations. care staff, including ated on the Dining Room Chart and on how the chart aff were educated that as will be the same as the as Assignment Chart. Initiated Investigative Training In With the ED and DNS. In Care in the interior of the interio	F	514			
	in-service will be inc Orientation for all ne utilize Agency Staff.	uded in New Employee w hires. The facility does not If the facility should employ vill receive the in-service prior					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ROSEWOOD HEALTH CARE CENTER			•	5	REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	 	
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F 514	that staff do not work in-service. A sign is protify staff they are nany resident prior to receive the in-servin-service is a charge a charge nurse on a cha	be responsible to validate prior to receiving the costed at the time clock to ot to work or provide care to reporting to a charge nurse ice. If the staff in need of nurse, they are to report to different unit. The Improvement Committee D. Members in attendance S, UM and RD. Was notified of the Facility 1/10. Inde WS will audit residents on	F	514			
	(two per unit) per we- exhibited and to valid been appropriately a comprehensive care but will not be limited Comprehensive Care	I audit four random records ek for any new behaviors late that all behaviors have ddressed on the plan. The audit will include to: the MDS Assessment, e Plan, Behavior and Mood rogress Notes for the					

NAME OF PROVIDER OR BUPPLIER ROSEWOOD HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, 2IP CODE		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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previous 7-day period. The DNS and CM will also review the meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed. In addition, the DNS and CM participate in the licensed staff dining room observation. In addition, the audit will include 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plan. The DNS will be responsible to report all audit (residents on mechanically altered diets, behaviors, and the Meal Supervision Logs) findings at the weekly PIC meeting. The PIC will meet weekly (Tuesday) for four weeks to review audit findings to determine the need for additional action steps. If no concerns are identified during the weekly (Tuesday) PIC meetings, the audits on a monthly basis for two months, and on an as needed basis thereafter. The DNS will be responsible to report all audit	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
findings will be reviewed at the monthly PIC to validate that any identified concerns were immediately corrected. Findings will be tracked and trended at the PIC for additional action steps, if indicated. The Interdisciplinary Team, to include but not limited to: ED, DNS, UM, RD, Social Worker,	F 514	previous 7-day period review the meal Super 7-day period to validate and/or concerns have addressed. In additional participate in the licer observation. In addition, the audit interviews of licensed per unit) per week to exhibited and to valid been appropriately rethe comprehensive of the comprehensive of the DNS will be resperved from the property of the comprehensive of the comprehensive of the DNS will be resperved from the property of the comprehensive of the DNS will be resperved from the property of the property of the concerns are identified in the property of	d. The DNS and CM will also ervision Logs for the previous atte that exhibited behaviors a been identified and on, the DNS and CM assed staff dining room will include 4 random staff I nurses and SRNAs (two identify any new behaviors ate that all behaviors have ported and addressed on are plan. onsible to report all audit nically altered diets, eal Supervision Logs) PIC meeting. The PIC will by for four weeks to review raine the need for additional entified during the weekly and on an as needed basis consible to report all audit by PIC meeting. All monthly and on an as needed basis consible to report all audit by PIC meeting. All monthly and at the monthly PIC to tiffied concerns were d. Findings will be tracked C for additional action steps,	F	514			

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ROSEWOOD HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 79 events during morning Stand-Ups by reviewing Event Reports, 24-Hour Reports, Hospitalizations, Dietary Communications Book to ensure that all events are investigated to ensure the health, safety and overall well-being is met and maintained for the affected resident, other facility residents with the potential to be affected, to identify the need for systemic changes and to			185089	B. WING			l .	
ROSEWOOD HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 79 events during morning Stand-Ups by reviewing Event Reports, 24-Hour Reports, Hospitalizations, Dietary Communications Book to ensure that all events are investigated to ensure the health, safety and overall well-being is met and maintained for the affected resident, other facility residents with the potential to be affected, to identify the need for systemic changes and to	NAME OF PE	SUMBER OF STREET IED	10000				09/2	2/2010
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events during morning Stand-Ups by reviewing Event Reports, 24-Hour Reports, Hospitalizations, Dietary Communications Book to ensure that all events are investigated to ensure the health, safety and overall well-being is met and maintained for the affected resident, other facility residents with the potential to be affected, to identify the need for systemic changes and to	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO	ION SHOUL	LD BE	(X5) COMPLETION DATE
The ED is responsible for overall compliance through attendance at the Stand -Up Meeting and by reviewing audits to ensure conducted. The ED will assume overall responsibility for the Performance Improvement Program at the Facility. The ED will utilize weekly (Wednesday) IDT recommendations to validate one medical record (from resident identified in the IDT Meeting) to ensure implementation of the Credible Allegation of Compliance. The ED/Administrator will then return to routine monitoring, of the facility systems each month as specified in the Facility Performance Improvement policy and procedure, when substantial compliance is achieved. In addition, the DDCO will conduct weekly calls with the facility to review events from the previous week to validate that all events are thoroughly investigated, to include care plan revision. Interviews conducted on 09/22/10, during the extended survey, with the DON and direct care staff (SW #2, RN #1, RN #3, LPN #2, LPN #6, LPN #7, LPN #8, CNA #3, CNA #6, CNA #6, CNA #11, CNA #13, CNA #14 and CNA #15), revealed there was now a sealing chart for the	F 514	events during mornin Event Reports, 24-Ho Dietary Communication events are investigate safety and overall we maintained for the aff residents with the polition of the events are investigate validate that the PI pr The ED is responsible through attendance a by reviewing audits to will assume overall re Performance Improve Facility. The ED will utilize we recommendations to (from resident identific ensure implementation of Compliance. The return to routine monition each month as specific Performance Improve when substantial com In addition, the DDCO with the facility to revieweek to validate that investigated, to include Interviews conducted extended survey, with staff (SW #2, RN #1, LPN #7, LPN #8, CN, #11, CNA #13, CNA #	g Stand-Ups by reviewing pur Reports, Hospitalizations, ons Book to ensure that all ed to ensure the health, ill-being is met and ected resident, other facility tential to be affected, to systemic changes and to rocess is effective. The for overall compliance at the Stand -Up Meeting and to ensure conducted. The ED esponsibility for the ement Program at the early (Wednesday) IDT validate one medical recorded in the IDT Meeting) to on of the Credible Allegation ED/Administrator will then altoring, of the facility ement policy and procedure, inpliance is achieved. Divil conduct weekly calls are events from the previous all events are thoroughly de care plan revision. The DON and direct care RN #3, LPN #2, LPN #6, A #3, CNA #5, CNA #6, CNA #14 and CNA #15),	F				

FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	185089	B. WIN	G		C 09/22/2010	
NAME OF PROVIDER OR SUPPLIER ROSEWOOD HEALTH CARE CENTER			550 H	I ADDRESS, CITY, STATE, ZIP CODE HIGH ST. VLING GREEN, KY 42101		722,2010
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staff were present in and Administrative staff com service. They were noted, the staff licensed staff in the castaff then documented the dining room and nurse and document in the resident's reconstruction of the nervealed Resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident #1 in the resident in the resident in a supervise staff in the resident in a supervise all po intak resident in a supervise all po intak resident in a supervise resident	the dining room for all meals taff participated in the dining revealed if any behaviors reported the behavior to the dining room. The licensed at it on the behavior log in reported it to the Charge ed on the 24 hour report and rd. Soon meal on 09/22/10 I was seated at a table by was placed on the table until as served. The CNA n next to the resident when Residents #4, #5, #6 and #7 idents with like diets and reporting observations of ensed staff during the meal. A Room behavior observation revealed each resident #,1 on revealed the resident was in in the area across from the w of staff. #1's comprehensive care	F	514			

PRINTED: 10/06/2010

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> 2. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER		L	I		09/2	2/2010
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				во	WLING GREEN, KY 42101		
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F 514	Continued From page	81	F	514			:
	comprehensive care in plans were updated to interventions to provide residents related to the food/drinks. A review of the in-servidirect care staff, dated 09/19/10 and 09/21/11 training on care plans assigned seating chars supervision, activity sand all behaviors (to i reaching for objects to documentation. In adwere in-serviced on 0 Documenting Resider and Services, and Do Medical Record and of Executive Director and received in-servicing of conducting investigations. Although it was determined to the property of a "D", base monitor for the on-going corrective actions taked interventions taked to the plant of the plant of the property of a "D", base monitor for the on-going corrective actions taked the plant of the plant	de supervision for the seir behaviors of grabbing for vice trainings provided to all d 09/17/10, 09/18/10, 0, revealed all staff received and care plan meetings, rts, dining/meal service eating groups, to report any include wandering or o include food/drink) and dition, Administrative Staff 19/20/10, on Documentation, ints' Health Status, Needs cumenting in a Resident's on the 24- Hour Report. The d Director of Nursing on 09/18/10 related to ons.					

Commonwealth of Kentucky Office of Inspector General Division of Health Care Western Enforcement Branch

TYPE "A" CITATION

Facility: Rosewood Health Care Center - SNF/NF

Date: 09/24/10

Administrator: Ms. Kathy Skaggs

Ref: KY# 15337

This citation is issued pursuant to KRS 216.555 and KRS 216.557 and 900 KAR 2:040 for violations of 902 KAR 20:300, Section 8(7)(a). The citation may be appealed according to the provision of 900 KAR 2:020, which states that a written request for a hearing must be made to the secretary of the Cabinet for Health Services within twenty (20) days of receipt of written notice of the action. Any penalty assessed for this citation may be appealed under the same provisions.

Based on the findings of an abbreviated survey concluded on September 22, 2010, the facility failed to provide supervision and monitoring for Resident #1 who had a known history of attempting to obtain food of regular consistency; even though, the resident was able to eat pureed food only.

Resident #1 was admitted to the facility on 12/16/08, with diagnoses including Cerebral Vascular Accident. Review of the resident's medical record revealed during June, 2009, the resident had choked on lasagna, and had been placed on a pureed diet with nectar thick liquids. Review of the resident's care plan revealed no evidence of interventions related to the resident's history of attempting to obtain food of regular consistency.

On 09/01/10, Resident #1 was in the dining room, at a table where bread was served to another resident prior to the meal. Resident #1 was observed, by a Certified Nursing Assistant (CNA), with bread in the resident's hand. The CNA went to the resident and obtained the bread from the resident, and removed the remaining bread from the table. Interviews with CNAs revealed the resident turned "purple" and staff summoned assistance from licensed staff. The Heimlich maneuver was completed, but failed to clear the resident's airway. Staff were unable to detect respirations or a pulse. Emergency Medical Services (EMS) was alerted. EMS arrived and utilized a Laryngoscope and forceps to remove bread from the back of Resident #1's throat. The resident was then sent to the hospital.

Interviews with CNAs and Licensed staff revealed all staff was aware the resident was impulsive around food, and had a history of attempting to obtain food of a regular consistency. However, staff stated they had not reported these resident behaviors to anyone. Interviews with facility staff revealed a care plan had been developed which included an intervention for the resident to receive the meal tray only when staff were able to sit at the table with him/her. Further interview revealed no additional interventions were implemented related to Resident #1's impulsiveness around food, and the repeated attempts to obtain food of a regular consistency.

The above failures of the facility to develop and implement interventions to supervise and monitor residents identified as high risk for choking presented an imminent danger and substantial risk that death or serious physical harm will occur.

ISSUED BY: Browt famenting, W DATE: 9/24/10	TITLE: NC/E
RECEIVED BY: Karly Skappl DATE: 09/24/10	TITLE: Exec. Direcke
DATE TO BE CORRECTED: September 24, 2010	
CORRECTED: Kathy Skarps	(DATE) 9/22/10
VERIFIED CORRECTED: Brust Sementin N	(DATE) 9/24/10